AMENDED STATE OF DELAWARE DONATED LEAVE PROGRAM

On February 2, 1996, Governor Carper signed "An Act to Amend Chapter 59, Title 29 of the Delaware Code Relating to the Merit System of Personnel Administration; and Providing for Donated Leave" (*Senate Bill No. 28 as amended*). This legislation establishes a "Donated Leave Program" for State officers and employees. The program is designed to aid employees suffering from *any illness or injury to the employee or to a member of an employees family which is diagnosed by a physician and certified by the physician as rendering the employee or the member of the employees family unable to work, or in the case of family member who does not work the medical equivalent of "unable to work" for a period greater than 5 calendar weeks* by enabling them to draw upon sick and annual leave donated by other employees. Employees may donate sick and annual leave in equal amounts directly to other specified employees suffering from illnesses pursuant to the terms and conditions set forth by the Act. They may also donate to the "Donated Leave Bank" which eligible employees may draw upon.

On July 18, 2000, Governor Carper signed "An Act to Amend Title 14 and Title 29 of the Delaware Code Relating to the Donated Leave Program" (*Senate Bill No. 253*). This legislation amends the donated leave program to allow State employees and public school district employees to receive donated leave not only for illness or injury to themselves but also for illness or injury to a spouse, son, daughter, or parent who resides with the employee and who requires the personal attendance of the employee.

Section 42 of the FY 2001 Budget Act eliminated the restriction of an employee making a donation within the last six months prior to their retirement from State employment.

The following is a brief summary of the major provisions of the Acts:

Please Note: The following provisions apply to all DONORS and DONOR RECIPIENTS in completing any Donated Leave Program form.

1. DONATED LEAVE

Employees may donate accrued sick and annual leave in equal amounts to other designated employees or to the "Donated Leave Bank". This means that any donation of sick leave must include an equivalent donation of annual leave.

2. DONATED LEAVE CONVERSION

The recipient's agency will convert the donated leave into cash value at the donor's rate of pay, shall re-convert the cash value to hours of leave at the recipient's rate of pay, and then credit the recipient's account for the equivalent hours.

3. ILLNESS*

Donated leave may be used by a recipient only for an illness* of the recipient or of a family member of the recipient. Separate periods of disability lasting 7 calendar days or more each, resulting from the same or related medical condition and occurring within any 12 consecutive month period, shall be considered the same period of disability. Definition of family member or member of any employee's family means an employee's spouse, son, daughter, or parent who

resides with the employee and who requires the personal attendance of the employee during the family member's illness or injury.

4. OTHER REQUIREMENTS

Before receiving donated leave time, the requesting employees shall: (1) have been a State officer or employee for at least 6 months prior to the request; (2) have used all of his or her sick days and half of his or her annual leave; however, when the donated leave time is for the illness* of a family member, the employee must have used all of his or her sick days and annual leave; and (3) have established medical justification for such receipt, which must be renewed every 30 days.

5. EFFECTIVE DATE

Direct donations are effective immediately; donations to the Donated Leave Bank do not become effective until the Donated Leave Bank is established, but no later than May 2, 1996.

6. PROGRAM MANAGEMENT

State Personnel has developed the following forms and process checklist for agencies (attached) to activate the provisions of the Act:

- DL-1: Request for Donated Leave
- DL-2: Request to Make a Direct Donation
- DL-3: Application to Make a Direct Donation to the Donated Leave Bank
- DL-4: Authorization to Release Information for Solicitation Purposes
- Agency Checklist of Steps for Processing Donated Leave Requests
- Donated Leave Program Calculation Worksheet

7. DONATED LEAVE REVIEW COMMITTEE

A Donated Leave Review Committee will help manage the Donated Leave Bank. The Committee will, for example, recommend which leave request should receive priority when there is insufficient leave time available in the Leave Bank to honor all requests.

8. DONATED LEAVE PROGRAM CHANGES

At the Human Resources Administrators' meeting held on January 28, 2002, the request was made for comments on realigning the Donated Leave Program. Based on the comments received, the following Donated Leave Program changes became effective as of February 24, 2002.

The realignment requires the agencies to:

- Review employee's request for Donated Leave and approve or deny based on information provided.
- Review medical certifications every 30 days for requests to extend Donated Leave approvals.
- Process Donated Leave calculation worksheets with direct donations received and pay employee accordingly.
- Maintain accurate documentation of requests, donations and payment for auditing purposes.

The State Personnel Office will:

- Maintain the Donated Leave Bank including processing donations and approving funds for disbursement. Agencies should:
  - Forward DL-3 forms for donations to SPO and
  - Forward Donated Leave Calculation Worksheets which include requests for hours/funds from Donated Leave Bank to SPO
- Send Statewide Donated Leave solicitations upon request from agencies.
- Provide guidance regarding administration of the program as needed.
- Audit the program and individual cases as needed.

9. SOLICITATION FOR DONATED LEAVE

After receiving authorization from the employee, agencies will first solicit Donated Leave donations within their own agency. Employees must complete the Donated Leave application including the DL-4, "Authorization to Release Information for Solicitation Purposes." Solicitations must comply with HIPAA regulations and not include any personal health information. Solicitations should state only that the employee is out of work due to an illness or injury.

After agencies have solicited for direct donations internally, they may request that the State Personnel Office distribute a Statewide Solicitation. A Statewide Solicitation will be sent upon request from the agency. The e-mail request must contain the verbiage to be included on the solicitation. If additional donations are needed, upon agency request, SPO will distribute a second Statewide Solicitation thirty days after the first solicitation.

The receiving agency will process all donations received through internal donations or as a result of a Statewide Solicitation. No documentation should be sent to the State Personnel Office unless requesting Donated Leave Bank hours. (See below)

10. DONATED LEAVE BANK REQUESTS

The requesting agency must solicit for donations internally within their agency and through the Statewide Solicitation process before requesting Donated Leave Bank hours. The State Personnel Office will distribute funds from the Donated Leave Bank as requested based on availability of funds. Agencies should request Donated Leave Bank hours in writing through e-mail. SPO will notify the agency that hours are available. The agency is required to forward copies of the DL-1 to SPO along with electronic versions of the Donated Leave calculation worksheets for each pay period Leave Bank hours are being requested.

SPO will submit the request for Donated Leave Bank hours to the Donated Leave Bank Committee for their review and recommendation for approval. SPO will notify the agency when the Donated Leave Bank request has been approved at which time they may then post the hours to the employees' account.

If the agency receives a direct donation internally for one of their eligible employees after the time the employee has been approved for Donated Leave Bank hours, the hours from the leave bank should be returned to the Donated Leave Bank if the employee is not in need of these additional hours.

11. DONATED LEAVE BANK DONATIONS

State agency employees wishing to make donations to the Donated Leave Bank must complete Part I of the DL-3: Application to Make a Direct Donation to the Donated Leave Bank. Equal amounts of sick and annual leave must be donated. The employee's Supervisor or Division Director must complete Part II of the DL-3 and the employee's personnel or payroll office must complete Part III. Forms must be forwarded to the State Personnel Office address listed on the DL-3. SPO will complete the form, return it to the agency, post and distribute the Donated Leave Bank hours as requests are received.

**Illness is defined as any illness or injury to the employee or to a member of an employees family which is diagnosed by a physician and certified by the physician as rendering the employee or the member of the employees family unable to work, or in the case of family member who does not work the medical equivalent of "unable to work" for a period greater than 5 calendar weeks.*

THE STATE OF DELAWARE

DL-1: Request for Donated Leave

NOTE: This Page is CONFIDENTIAL

Part I - To be completed by employee requesting donated leave

Name (Last, First, MI) Social Security # Date of Birth

Mailing Address (Street, City, State, Zip)

Agency (Name and Location) Date of Hire Work Telephone #

Illness* of: Employee Family Member of Employee (Check one box)

Family Member's Name: _____ Relationship to Employee: _____

Family Member's Present Address: _____

How long has the Family Member been a resident at the present address? _____

Date of Accident/ beginning of Illness _____ Date Disability began _____ Date Returned to Work _____

Briefly describe nature of illness/injury

Name of treating physician Physician's address Physician's Telephone # Treatment Date

Date all sick leave exhausted _____ Date one-half annual leave exhausted _____

Date all annual leave exhausted _____

Describe any other income you are receiving or are eligible to receive as a result of your disability.
(Examples: Social Security, Worker's Compensation, Disability Insurance, Pensions, etc.)

Upon presentation of the original or a photocopy of this signed authorization, I authorize any medical professional, hospital, medical institution, pharmacy, governmental agency, or my present employer having information concerning me, to release said information to the State of Delaware or its designated representative to be used for determination of my eligibility for Donated Leave. This authorization shall be valid from the date signed through the duration of this claim.

Employee Signature Date

Part II – To be completed by the employee's agency personnel/payroll office

The above-named employee has:

- used, or will use, all accrued sick leave on _____
- used, or will use, one-half of his/her accrued annual leave on _____
- used, or will use, all of his/her accrued annual leave on _____
- has been employed by the State for (6) months as of _____
- last worked on _____

(NOTE: For illness* or injury of a family member, employee must have used all of his/her sick and annual leave.)

_____ _____ _____

Authorized Signature | Date | Recipient's Agency

Agency Address – (please include SLC): _____

Part III – To be completed by the Donated Leave Bank Committee (Leave Bank Requests Only)

We have reviewed the donated leave request to determine if the employee meets all criteria for the Donated Leave Program.

We recommend: _____ Denial _____ Approval granted through _____. For applicant to be eligible to receive Donated Leave beyond the above date, applicant must submit physician's certification certifying continued disability/illness.

Based upon hours currently available in the State of Delaware Donated Leave Bank we further recommend that _____ be awarded _____ hours of donated leave from the State of Delaware Donated Leave Bank.

_____ _____ _____ _____

Agency Representative | Date | State Personnel Office Representative | Date

_____ _____

Employee Representative | Date

Part IV –To be completed by State Personnel Director or Designee (Donated Leave Bank Only)

I hereby certify that I have reviewed this application and the recommendation of the Donated Leave Bank Review Committee and hereby approve/disapprove _____ for the receipt and use of donated leave. Further, based upon the recommendation of the Donated Leave Bank Review Committee, I am authorizing transfer of _____ hours from the State of Delaware Donated Leave Bank to _____.

_____ _____

State Personnel Director/Designee | Date

Upon completion, please forward to applicant's agency personnel/payroll office.

Part V – To be completed by applicant's agency personnel/payroll office

I hereby certify that (1) this applicant has been an officer or employee of this State for at least 6 months (2) has used all of his/her sick time and one-half of his/her annual leave (for illness/injury of family member – has used all of his/her sick time and all of his/her annual leave) and (3) has established medical justification for such receipt, which shall be renewed every 30 days. I further certify that the applicant has been credited with _____ hours of Donated Leave from the State of Delaware Donated Leave Bank.

_____ _____

Authorized Signature Date

**Illness is defined as any illness or injury to the employee or to a member of an employees family which is diagnosed by a physician and certified by the physician as rendering the employee or the member of the employees family unable to work, or in the case of family member who does not work the medical equivalent of "unable to work" for a period greater than 5 calendar weeks.*

THE STATE OF DELAWARE

Request to Receive Donated Leave

Note: This Page is CONFIDENTIAL

Part VI-To be completed by physician who is treating employee or employee's family member.

1. Name of Patient _____ Date of Birth _____

Present Address _____ SS# _____

2. If patient is the employee's seriously ill family member please complete the following:

- Is hospitalization of family member (patient) required? Yes No
- Does (or will) patient need help for basic medical, hygiene, nutrition, safety or transportation? o Yes o No
- Is the employee's presence necessary, or would it be beneficial for care of the patient? o Yes o No
- Please describe the care required and the estimated time allotted for treatment.

_____
_____
_____

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

This patient is responsible for the completion of this form without expense to the State of Delaware. We must have comprehensive medical information in order to evaluate the insured's claim for Donated Leave.

4. HISTORY

(a) When did the symptoms first appear or accident happen? Mo. _____ Day _____ 20_____

(b) Date disability began Mo. _____ Day _____ 20_____

(c) Has patient ever had same or similar condition? Yes _____ No _____

If "yes" please give details _____

(d) Is condition due to injury or sickness arising out of patient's employment? Yes _____ No _____ Unknown _____

4. DIAGNOSIS (including any complications)

(a) When did symptoms first appear or accident happen? Mo. _____ Day _____ 20_____

(b) Diagnosis and ICD-9 or DSM-IV Code (including any complications)

(c) Subjective symptoms

(d) Objective findings (Including current x-rays, EKG's, Laboratory Data and any clinical findings)

5. TREATMENT DATES

(a) Date of first visit Mo. _____ Day _____ 20_____

(b) Date of last visit Mo. _____ Day _____ 20_____

(c) Frequency Weekly _____ Monthly _____ Other(specify) _____

1. NATURE OF TREATMENT (including surgery and medications prescribed, if any)

Will treatment substantially improve function and employability? Yes _____ No _____

If yes, please specify.

2. PROGRESS

(a) Has patient recovered? _____ improved? _____ unchanged? _____ retrogressed? _____

(b) Is patient bed confined?_____ hospital confined?_____ ambulatory?_____ house confined? _____

(c) Has patient been hospital confined? Yes_____ No_____

If yes, give name and address of hospital _____

Confined from _____ through _____
_____

3. CARDIAC (if applicable)

(a) Functional capacity Class 1 (no limitation) _____ Class 2 (slight limitation) _____

(American Heart Assoc.) Class 3 (marked limitation) _____ Class 4 (complete limitation) _____

(b) Blood Pressure (last visit) Systolic _____ Diastolic _____

4. LIMITATION (if there is a limitation, check and describe below)

standing _____ climbing _____ bending _____ use of hands _____
sitting _____

walking _____ stooping _____ lifting _____ psychological _____ other _____

5. PHYSICAL IMPAIRMENT (as defined in Federal Dictionary of Occupational Titles)

____ Class 1 – no limitation of functional capacity; capable of heavy work. No restrictions (0-20%)

____ Class 2 – medium manual activity (15-30%)

____ Class 3 – slight limitation of functional capacity; capable of light work (35-55%)

____ Class 4 – moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity (60-70%)

____ Class 5 – severe limitation of functional capacity; incapable of minimal (sedentary) activity (75-100%)

____ Remarks:

Do you believe the patient is competent to endorse checks and use the proceeds thereof? Yes ___ No ___

6. EXTENT OF DISABILITY

	From Patient's Regular Occupation	From any Occupation
(a) Is patient now totally disabled?	Yes _____ No _____	Yes ____ No ____
(b) If no, when was patient able to go to work?	Mo.____ Day____ 20____	Mo._____Day____ 20___
(c) If yes, when do you think patient will be able to resume any work?	Mo.____ Day____ 20____	Mo._____Day____ 20___

7. REMARKS

Date	Signature (attending physician)	Degree	Telephone Number
Street Address	City	State	Zip Code

Upon completion, please forward to applicant's agency personnel/payroll office.

**Illness is defined as any illness or injury to the employee or to a member of an employees family which is diagnosed by a physician and certified by the physician as rendering the employee or the member of the employees family unable to work, or in the case of family member who does not work the medical equivalent of "unable to work" for a period greater than 5 calendar weeks.*

THE STATE OF DELAWARE

DL-2: Request to Make a Direct Donation

Part I – To be completed by Donor employee–(Must donate equal amounts of sick and annual leave)

Donor's Name _____ Social Security # _____

Agency _____ Work Phone # _____

I hereby donate _____ hours of annual leave and _____hours of sick leave **(must be equal amounts)** to:

_____ _____

Recipient's Name Recipient's Agency

I understand that in order to donate leave that I must donate an equal amount of annual leave and sick leave. I understand that my annual leave and sick leave balances will each be reduced by the number of hours donated as indicated above. If requested by the recipient, [ ] you may [ ] may not release my name and donation information to the recipient. [ ] You may [ ] may not contact me if additional hours are needed.

_____ _____

Donors' Signature Date

Upon completion, please forward to your Supervisor or Division Director.

Part II – To be completed by the donor employee's Supervisor or Division Director

I hereby _____ approve _____ disapprove the donation of leave for the above named employee.

_____ _____ _____

Authorized Signature Date Agency

Upon completion, please forward to donor employee's agency personnel/payroll office.

Part III – To be completed by the donor employee's agency personnel/payroll office

I hereby certify the following:

_____ _____

Donor's Name Donor's hourly rate of pay & date effective

The donor has sufficient annual leave and sick leave hours to cover the donation indicated in Part I.

_____ _____

Authorized Signature Date

_____

Donor's Agency Address (include SLC)

Upon completion, please forward to the recipient's personnel/payroll office.
Copy to Timekeeper, if applicable.

Part IV – To be completed by the recipient employee's agency personnel/payroll office

Check one of the boxes for the action taken on the leave donation covered by this form and complete the information requested to include the appropriate authorized signature.

❑ I have attached a copy of a Donated Leave Calculation Worksheet for _____
Recipient's Name
for the pay period ending _____ which has been approved by the recipient's agency.

The Donor's sick leave and annual leave accounts should be charged for the following:

Sick Leave _____ hours Annual Leave _____ hours Paycycle _____

Sick Leave _____ hours Annual Leave _____ hours Paycycle _____

Sick Leave _____ hours Annual Leave _____ hours Paycycle _____

I hereby certify the above information and further certify that the recipient has made application and been approved for receipt of donated leave.

_____ _____
Authorized Signature Date

_____
Recipient's Agency Address (include SLC)

❑ The recipient has excess leave donations. The donor's leave donation is not needed at this time, please restore the donor's sick and annual leave.

_____ _____
Authorized Signature Date

_____
Recipient's Agency Address (include SLC)

Upon completion, please forward to donor employee's agency personnel/payroll office.

Part V – To be completed by donor employee's agency

I hereby certify that the donor's sick leave balance and annual leave balance have been reduced by the following:

Sick Leave _____ Hours Annual Leave _____ Hours

_____ _____ _____
Authorized Signature Phone Number Date

Upon completion, please forward to the recipient's agency personnel/payroll office.

THE STATE OF DELAWARE

DL-3: Application to Make a Direct Donation to the Donated Leave Bank

Part I – To be completed by donor employee

Donor's Name _____ Social Security # _____

Agency _____ Work Phone # _____

I hereby donate _____ hours of annual leave and _____ hours of sick leave (**must be equal amounts**) to the Donated Leave Bank.

I understand that my annual leave and sick leave balances will be reduced by the amount of donation I have indicated above.

_____ _____
Donor's Signature Date

Upon completion, please forward to your Supervisor or Division Director.

Part II – To be completed by the donor employee's Supervisor or Division Director

I hereby ____ approve _____ disapprove the donation of leave for the above named employee.

_____ _____ _____
Authorized Signature Date Agency

Upon completion, please forward to donor employee's agency personnel/payroll office.

Part III – To be completed by the donor employee's agency personnel/payroll office

I hereby certify the following:

_____ _____
Donor's Name Donor's hourly rate of pay & effective date

The donor's sick leave balance will be reduced by _____ hours and the donor's annual leave balance will be reduced by _____ hours as of the pay period ending _____

_____
Authorized Signature Agency Address (include SLC) Date

Upon completion of this form, please forward to:

Office of State Personnel, Benefits Unit
655 South Bay Rd.
Blue Hen Corporate Center, Suite 202
Dover, DE 19901
Phone: 302-739-8331
SLC: D620E

Part IV – To be completed by the State Personnel Director or Designee

a. _____
Donor's Name

b. _____
Donor's hourly rate of pay

c. _____
Total Hours Donated

d. _____
$ Value of donor's donated hours

I hereby affirm that the above information is true and correct to the best of my ability and will make certain that this donation be credited to the Donated Leave Bank.

_____ _____
State Personnel Director or Designee Date

Upon completion, SPO will return signed original to the donor's agency, and file a copy for their records.

THE STATE OF DELAWARE

DL-4: Authorization to Release Information for Solicitation Purposes

To be completed by employee seeking leave donations from other employees

Name (Last, First, MI) _____

Agency _____ Date of Hire _____

Illness* of (check one) [ ] Employee [ ] Employee's Family Member

If employee's Family Member: Relationship to employee _____

Name of Family Member _____

Family Member's present address _____

How long has the Family Member been a resident at the present address? _____

Date of accident or beginning of sickness _____

Date you became unable to work _____

Date you plan to return to work _____

Briefly describe the nature of the illness/injury: _____

_____

Date all Sick Leave will be/was exhausted	Date one-half Annual Leave will be/was exhausted	Date all Annual Leave will be/was exhausted
_____	_____	_____

Other Sources of Income Continuation (complete the following information where applicable; otherwise, indicate "not applicable" or "not eligible.")

	Number Hours	Benefit Amount	Date Payment Begins	Date Payment Ended
State Retirement/Disability Pension	_____	_____	_____	_____
Pay Pending Disability Pension Determination	_____	_____	_____	_____
Compensatory Time	_____	_____	_____	_____
Social Security	_____	_____	_____	_____
Private Disability Income Insurance	_____	_____	_____	_____
Workers' Compensation	_____	_____	_____	_____
Worker's Compensation Supplement Pay	_____	_____	_____	_____
Leave Donations from Spouse or Other Relatives	_____	_____	_____	_____
Any Other Income Sources	_____	_____	_____	_____

I understand that leave donations will be normally solicited in the following order. My agency or department will determine the actual order of the solicitation based upon the information provided. Please provide the information requested and any other suggestions you may have for soliciting leave donations.

1. The employees listed below with whom I have already spoken to concerning a donation. (Recipient should provide each employee with a DL-2: Request to Make a Direct Donation.)

Employee Name	Agency	Work Location	SLC

2. My current work unit is: _____

3. My current work facility (e.g., Stockley Center) is: _____

4. Any prior work unit. My previous work units were:

Work Unit	Agency	Location

5. My current division (e.g., Public Health, Motor Vehicle) is: _____

6. My department or agency (e.g., Correction, DHSS) is: _____

7. Other specific departments or agencies that I interact with in my job or would be a good source for donations for other reasons. Please indicate any specific departments or agencies: _____

8. Statewide Solicitation

I hereby authorize release of the information indicated above to solicit hours on my behalf under the State of Delaware Donated Leave Program. I understand that this information will be shared with employees requesting information in connection with my request for leave donations.

_____ _____

Employee Signature Date

Upon completion, please forward to applicant's agency personnel/payroll office.

**Illness is defined as any illness or injury to the employee or to a member of an employees family which is diagnosed by a physician and certified by the physician as rendering the employee or the member of the employees family unable to work, or in the case of family member who does not work the medical equivalent of "unable to work" for a period greater than 5 calendar weeks.*

THE STATE OF DELAWARE

Agency Checklist of Steps for Processing Donated Leave Requests

DL-1: Request for Donated Leave

1. Recipient employee completes Part I of the "DL-1 Request for Donated Leave" with the exception of the dates sick and annual leave are exhausted and has attending physician complete "Part VI – Physician's Statement." Employee also completes the "DL-4 Authorization to Release Information for Solicitation Purposes."

2. Recipient employee submits the completed DL-1, including Physician's Statement, and completed DL-4 to their agency personnel/payroll office for processing.

3. Recipient employee's agency personnel/payroll office verifies recipient is eligible to receive donated leave and completes all of Part II of the DL-1; and Part I for the dates the employee's sick and annual leave are exhausted.

4. Recipient employee's agency personnel/payroll office determines order of solicitation and initiates solicitation steps.

DL-2: Request to Make a Direct Donation

1. Donor completes Part I of the DL-2 - "Request to Make a Direct Donation" and submits the application to their Supervisor or Division Director.

2. Donor's Supervisor or Division Director will approve or disapprove the donor's donation, complete Part II of the DL-2, and forward to the donor's agency personnel/payroll office.

3. Donor's agency personnel/payroll office completes Part III of the DL-2, certifying donor's hourly rate of pay, effective date of pay rate, and availability of hours and forwards to recipient employee's agency personnel/payroll office.

4. Recipient employee's agency personnel/payroll office completes a "Donated Leave Calculation Worksheet" for each pay period included in the request for Donated Leave to determine need for donated hours.

5. Recipient employee's agency personnel/payroll office completes Part IV of the DL-2, indicating the disposition of donated hours and forwards the completed DL-2 form to the donor's agency personnel/payroll office.

6. Donor's agency completes Part V of the DL-2, certifying the reduction of hours made to the donor's sick leave and annual leave accounts and files a copy in donor's file. Donor's agency returns the DL-2 to the recipient's agency personnel/payroll office.

DL-3: Application to Make a Direct Donation to the Donated Leave Bank

1. Donor completes Part I of the DL-3, "Application to Make a Direct Donation to the Donated Leave Bank" and submits the application to their Supervisor or Division Director.

2. Donor's Supervisor or Division Director will approve or disapprove the donation, complete Part II of the DL-3, and forward to the donor's agency personnel/payroll office.

3. Donor's agency personnel/payroll office certifies donor's hourly rate of pay and reduces donor's sick leave and annual leave accounts; completes Part III of the DL-3, and forwards the application to the State Personnel Office Benefits Unit. (Send to the address on the DL-3 form.)

4. The Office of State Personnel completes Part IV of the DL-3, certifying hours and dollar value of donation credited to the Donated Leave Bank, returns signed original form to donor's agency, and files a copy for their records.

5. Donor's agency files application in donor's file.

6. SPO emails the "Funds Available in the Donated Leave Bank" memo to all Statewide Donated Leave agency personnel to inform them of available funds.

DL-4: Authorization to Release Information for Solicitation Purposes

1. Recipient employee completes DL-4 and forwards to their agency personnel/payroll office for reference by employees wishing to donate leave. (This form should be completed and turned in with the DL-1 form).

2. Recipient employee's agency personnel/payroll office forwards DL-2 forms to employees named by the recipient employee; advises agency employees of employee request for donation and informs agency employees that more specific information is on file in the agency personnel office.

3. If sufficient donations do not materialize within the recipient employee's work unit, agency personnel office expands solicitation to recipient employee's work facility, prior work units, division, department or agency.

4. If sufficient donations are not received, the recipient's agency may request that the State Personnel Office distribute up to two Statewide Solicitations, thirty-days apart.

5. If sufficient funds are still not received, the recipient's agency may request Donated Leave Bank hours. The State Personnel Office administers the Donated Leave Bank.

Direct Donation Solicitation

1. Recipient's agency distributes solicitation(s) for Donated Leave within their organization and to employees named by the recipient employee on the DL-4 form; advises agency employees of employee request for donation and informs agency employees that specific information is on file in the agency personnel office.

2. Direct Donations are processed by the recipient's agency not SPO. Documentation <u>should not</u> be forwarded to the State Personnel Office <u>unless</u> requesting Donated Leave Bank hours.

Statewide Donated Leave Solicitations

1. If additional donations are required, the recipient's agency may request a Statewide Solicitation from the State Personnel Office (SPO), Benefits Unit. Thirty days after the initial Statewide Solicitation is sent, the agency may request a second Statewide Solicitation from SPO. If sufficient donations are not received after the second Statewide Solicitation, the recipient's agency may request Donated Leave Bank hours.

2. Requests for Statewide Solicitations should be sent to the State Personnel Office via e-mail. Requests should include the exact verbiage to be used in the Statewide Solicitation as well as the name and address of person at the recipient's agency who should receive the forms.

3. Direct donations received as results of a Statewide Solicitation are processed by the recipient's agency; not SPO. Documentation <u>should not</u> be forwarded to the State Personnel Office unless requesting Donated Leave Bank hours.

Donated Leave Bank

1. Donated Leave Bank hours are approved and awarded in the order they are received when funds are available. The State Personnel Office notifies the Donated Leave Committee by e-mail that a request has been made and reviews the application and provides a recommendation regarding recipient employee eligibility and award of hours from the State of Delaware Leave Bank.

2. The State Personnel Director, or his/her designee, will approve or disapprove the Donated Leave Committee's recommendation.

3. The recipient's agency forwards copy of the DL-1 and supporting Donated Leave Calculation Worksheets to the State Personnel Office.

4. The State Personnel Office emails the recipient employee's agency contact that the request for donated leave from the Donated Leave Bank has been approved, and forwards a copy of the completed DL-1 to the recipient employee's agency personnel/payroll office.

5. The recipient employee's agency personnel/payroll office credits the employee with any approved donated leave received from the Donated Leave Bank using the "Donated Leave Calculation Worksheet."

Donated Leave Calculation Worksheet

1. The "Donated Leave Calculation Worksheet" is to be used by the recipient employee's agency personnel/payroll office to calculate the conversion of hours from donors to the recipient and to document the source and use of donated leave on a pay period basis.

2. Recipient employee's agency personnel/payroll office enters information into the calculation spreadsheet. Some fields will calculate automatically. The following is an explanation of each field on the spreadsheet.

Pay Period Data:

Paycheck Date
: Enter the check date of the pay period this worksheet represents. (Refer to the PHRST System Schedule of Due Dates available on the PHRST web site.) Complete a separate worksheet for each biweekly pay period.

Pay Period
: Enter the dates of the pay period this worksheet represents. (Refer to the PHRST System Schedule of Due Dates available on the PHRST web site.) Complete a separate worksheet for each biweekly pay period. Donated Leave must be applied beginning with the earliest date employee is on leave without pay. Donated Leave must be used concurrently with FMLA if the recipient is in an unpaid status while on FMLA.

Number of Work Days
: Enter the number of workdays in the pay period. If the pay period includes holidays, include those days in the total number for the pay period.

Recipient Data:

Employee Name
: Enter the employee's name.

Hours/Day
: Enter the hours normally worked per day by the recipient employee.

Total Pay Period Hours
: Calculated field (Number of Work Days multiplied by amount in Hours/Day)

Hours Worked
: Enter the number of hours the employee worked during the pay period. This field should be left blank if the employee did not work during the entire pay period.

Sick Leave/Monthly Accruals
: Enter the number of hours of the recipient's sick leave used during the pay period. Include any sick leave accruals used as they are accumulated. (Recipient employee will continue to accrue sick leave each month that the employee remains in a paid status.)

Annual Leave/Monthly Accruals
: Enter the number of hours of the recipient's annual leave used during the pay period. Include any annual leave accruals used as they are accumulated. (Recipient employee will continue to accrue annual leave each month that the employee remains in a paid status.)

Holiday Pay
Enter the number of hours of holiday pay included in the pay period.
Comp Time
Enter the number of hours of the recipient's comp time used during the pay period.
Hours Not Covered by Donated Leave/Docked Hours
Enter the number of hours not eligible for Donated Leave or hours that were docked.
Bal. Forward from Pervious Worksheet
Enter Donated hours remaining from the worksheet from the previous pay period. This would show as a negative number in the "Remaining Requested Hours" field. (Must be entered as a positive number in this field.)
Total Hours Requested
Calculated field (Total Pay Period Hours minus sum (Hours Worked, Sick Leave, Annual Leave, Holiday Pay, Comp Time, Hours Not Covered by Donated Leave/Docked Hours, and Bal. Forward from Previous Worksheet))
Biweekly Rate
Enter recipient's biweekly rate of pay
Hourly Rate
Enter recipient's hourly rate of pay

Donor Data:
Donor Name
Enter name of each donor.
Original Donation
Enter the amount of the original donation from each donor listed on the worksheet. If a donation exceeds the need for the pay period represented on the worksheet, remaining hours must be carried over to the next spreadsheet in the ""Bal. Forward from Pervious Worksheet" field. If donations exceed the need for donations, hours must be returned to the donor.
Donation Used
Enter the number of hours donated by each donor.
Donation Not Used
Calculated field. (Original Donation minus Donation Used)
Donor's Hourly Rate
Enter each donor's hourly rate of pay.
Donor Hours Converted to Recipient
Calculated Field. (Donation Used multiplied by Donor's Hourly Rate)
Remaining Requested Hours
Calculated Field. (Total Hours Requested minus Donor Hours Converted to Recipient)
If this number is a positive number, the recipient is still in need of Donated Leave hours for this pay period.
If this number is a negative number, the recipient has received excess hours and the remaining hours may be carried over to the next pay period's worksheet in the "Bal. Forward from Previous Worksheet" field on the next worksheet. Enter as a positive number on the next worksheet.
If the recipient is no longer in need of Donated Leave, the excess hours must be returned and credited back to the donor.
Agency Certification
Must be signed and dated by an authorized signer designated by each agency.

3. Recipient employee's agency personnel/payroll office certifies the "Donated Leave Calculation Worksheet" and enters the hours in the PHRST payroll system. Hours must begin to be credited on first day.

4. Worksheets <u>should not</u> be forwarded to the State Personnel Office unless recipient's agency is requesting Leave Bank hours and there are hours available in the Leave Bank. (See Donated Leave Bank.)